DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 12/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

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F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at the facility from November 16, 2009 through December 2, 2009. The deficiencies contained in this survey are based on observations, interviews and review of residents' clinical records and other facility documentation as indicated. The survey sample included thirty (30) admission and forty (40) census residents in Stage I. The Stage II sample included forty-three (43) residents.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	**F 157 Notification of Changes** **1.** **a.** R65's physician was notified on 10/31/09 and orders received regarding treatment. **b.** R87's family was informed of use of he antipsychotic drug and diagnosis for use. The medication was discontinued as per family request. **c.** R234's Physician was notified of lab values. Resident discharged to home on 2/6/09. **2.** **a.** All incident reports within the last 90 days will be audited by D.O.N./ designee to confirm physician notification. Corrective action will be taken as indicated. February 1, 2010. **b.** All resident's medical records on antipsychotic medications will be audited by D.O.N./designee weekly	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and review of other documentation, it was determined that the facility failed to promptly consult with the physician and/or responsible family member for 3 residents (R65, R87 and R234). The facility failed to promptly consult with R65's physician when there was an accident involving the resident on 10/30/09 which resulted in injury and had the potential for requiring physician intervention. The facility failed to notify R87's responsible party of a new diagnosis for the resident and use of an antipsychotic medication. The facility failed to notify R234's physician of abnormal laboratory (lab) values and an interested family member of abnormal lab values and a significant weight loss on 1/24/09. Findings include: cross-refer to F309 1. R65 received large skin tears to her lower legs while being transferred to the bed by medics on 10/30/09. R65 experienced bleeding which required direct pressure and bandages. R65 was on the anticoagulant (blood thinner) Coumadin and Aspirin, which delay the ability of the blood to clot. R65 also experienced a significant amount of pain related to her injuries. The facility failed to promptly notify the physician of R65's injuries promptly. When the physician was notified nearly 24 hours later due to R65's continued bleeding, an order was obtained to send the resident to the ER for treatment to control the bleeding.	F 157	to confirm that the responsible party was notified regarding use of antipsychotic medication and the diagnosis for use. Corrective action will be taken as indicated. February 1, 2010. **c.** The D.O.N./designee will conduct a random audit of medical records (40% of census) to confirm that the physician was notified of laboratory values and weight loss will be conducted. Corrective action will be taken as indicated. February 1, 2010. **3.** **a.** Nursing staff will be educated by Staff Developer on physician notification of incidents, abnormal lab values, weight loss and notifying responsible party regarding implementation of antipsychotic medications and corresponding diagnoses. February 1, 2009. **b.** Incident reports will be brought to stand up meeting and reviewed by NHA/designee to ensure physician notification is documented on report. February 1, 2010. **c.** New orders for antipsychotic medications will be reviewed at high risk meeting and audited weekly by D.O.N./designee for responsible party notification of order and diagnosis for use. February 1, 2010.	2/1/10 2/1/10 2/1/10 2/1/10 2/1/10

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F 157	Continued From page 2 During an interview with the Unit Manager (E5) on 12/1/09, she confirmed that the MD (E22) was unaware of R65's injuries until he was notified by a day shift nurse on 10/31/09. E5 stated that the wound nurse (E19) should have contacted the physician when she filled out the initial incident report. Findings were reviewed with administrative staff during the exit conference on 12/2/09. 2. R87 was admitted 4/25/09 status post heart surgery for rehabilitation and had mild dementia. On 5/11/09 a physician' order was written to start Seroquel (anti-psychotic) 12.5 mg. late in evening for sundowners with psychosis after a psychiatric nurse practitioner (E7) assessed the resident on 5/7/09. There was no evidence that the resident's responsible party was informed of this new diagnosis and use of an anti-psychotic medication. The family requested the medication be stopped on 5/14/09 when they became aware. The resident had only taken one dose and refused the rest of the doses until it was discontinued. Interview with the DON (E2) and Administrator (E1) on 12/2/09 confirmed this finding. 3. Cross refer F327. Record review revealed that R234 had approximately a 12 pound weight loss in one week. In addition, on 1/24/09, R234 had abnormal laboratory results of BUN and creatinine at 65 and 2.0 respectively (BUN, creatinine, and sodium levels are indicators of fluid imbalance and renal function). Interview with the attending physician (E22) on 12/2/09 at	F 157	**d.** Laboratory results will be brought to standup meeting and reviewed by D.O.N./designee to ensure physician notification. February 1, 2009. **e.** The weight loss book will be brought to high risk meeting to confirm physician notification and high risk review. February 1, 2010. **4.** Audits on all areas listed above will continue monthly. Results will be reviewed in quarterly QI meeting for a minimum of two quarters or until substantial compliance is achieved. February 1, 2010.	2/1/10 2/1/10 2/1/10

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F 157	Continued From page 3 approximately 2:30 PM revealed that he did not recall being notified of the laboratory results on 1/24/09. In addition, interview with the interested family member on 12/4/09 at approximately 1 PM revealed that he was not notified of the weight loss or the abnormal laboratory results on 1/24/09. Findings were reviewed with administrative staff during the exit conference on 12/2/09.	F 157		
F 166 SS=D	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R87) out of 43 sampled residents the facility failed to promptly resolve a concern expressed by the resident's responsible party. Findings include: An interview with the family member of R87 revealed that they made several complaints and had meetings with the facility about their concerns. Copies of correspondence that the family submitted to the facility were provided to the surveyor. On 5/13/09 the family member made the facility aware that on 5/13/09 at 5:50 AM a staff person transferred the resident (who was on sternal precautions post heart surgery) by grabbing R87 around the ribs and roughly putting her back to bed. The family member requested a complete assessment including a chest x-ray related to	**F 166 Grievances** **1.** R87 no longer resides at the facility. **2.** Concern forms for the last 90 days will be reviewed by the NHA/designee to ensure that documentation of resolution is present. Corrective action will be taken as needed. February 1, 2010. **3.** **a.** All staff will be educated by the Staff Developer on the process for reporting resident concerns. February 1, 2010. **b.** RNs, LPNs and Managers will receive additional training on the process for completing a concern form. February 1, 2010. **c.** NHA/designee will audit concern forms on a monthly basis to ensure resolution to any issues identified is documented. Corrective action will be initiated as needed. February 1, 2010. **4.** Audit results will be reported at the quarterly QI committee meeting for a minimum of 2 quarters or until substantial compliance. February 1, 2010.	2/1/10 2/1/10 2/1/10 2/1/10 2/1/10

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F 166	Continued From page 4 complaints of pain. Interviews on 11/30 and 12/1/09 with the social worker (E4) and DON (E2) revealed they had no concern form and did not remember this specific complaint. They had no further evidence that this concern was addressed. Review of the record revealed no nurses' or social service notes about this incident. There was a chest X-ray done on 5/18/09 that was negative, but there was no physician's order or reason noted for the chest X-ray. No physical assessment of the resident was documented during this period of time. The facility's policy for Resident Concern/Grievance indicated that all concerns will be documented using a specific form, forwarded to the social service director and administrator, reported to the state if indicated and notification to the complainant of follow up on the concern. There was no evidence that this was done for R87.	F 166		
F 174 SS=B	483.10(k) TELEPHONE The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to have a private phone for residents to use on the secured unit of the facility. Findings include: Observations made on the Holly unit during the survey noted two telephones, one at the nurses' station and one behind a couch on the wall in the	F	**F174 Telephone** **1.** No specific resident was cited. **1.** A new phone line to be placed in the Blue Lagoon (private area with seating). February 1, 2010. **2.** (1) Staff Developer to educate Holly Unit staff on resident use of the phone in the Blue Lagoon and the need to provide privacy for phone use if resident desires. February 1, 2010. (2) NHA will round Holly Unit weekly to ensure residents are offered privacy if they desire when talking on the phone. February 1, 2010. **3.** Results of rounds will be reviewed in quarterly QI meeting for a minimum of two quarters or until substantial compliance is achieved. February 1, 2010.	2/1/10 2/1/10 2/1/10 2/1/10

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F 174	Continued From page 5 day room. Interview with the unit manager (E8) on 11/20/09 revealed that residents on this unit receive and make calls on the telephone behind the couch so they can sit down and talk. Interview with the DON (E2) and Administrator (E1) on 12/2/09 confirmed that there was not a private phone on the Holly unit and a private phone would be provided in the near future.	F 174		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported		**F 225 Staff Treatment of Residents** **1.** **a.** The appropriate State Agency was notified of R65's incident on 11/2/09. **b.** R87 no longer resides at the facility. **2.** **a.** All incident reports completed within the last 90 days will be audited by D.O.N./designee to confirm State Agency notification. Corrective action will be taken as indicated. February 1, 2010. **b.** Incident reports and concern forms completed within the last 90 days will be audited by D.O.N./designee to confirm any allegations of mistreatment have been reported to the appropriate state agency. Corrective action will be taken as indicated. February 1, 2010.	2/1/10 2/1/10

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F 225	Continued From page 6 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview, it was determined that the facility failed to immediately report an accident with injury to the State Agency for R65. Additionally, the facility failed to thoroughly investigate an allegation of mistreatment for R87 and failed to report it to the State Agency. Findings include: cross-refer to F309 1. R65 accidentally sustained large skin tears to her shins when medics attempted to transfer the resident from a stretcher onto her bed on day shift on 10/30/09. R65 had bleeding from the wounds and extensive bruising. She was sent to the ER on 10/31/09 to treat the continued bleeding, which included sutures. The facility failed to report this incident to the State Agency until 11/2/09. The Assistant Director of Nursing (E3) was interviewed on 12/1/09. E3 stated that she was unaware of the incident until 11/2/09 when she reported it, although she had worked day shift on 10/30/09 when the incident occurred. When asked who reported incidents to her, E3 stated that nurses are to let her know of incidents "right away", however, she was not notified.	F 225	**3.** **a.** Administrative nursing staff will be responsible for reporting to the state agency on all shifts, according to regulation. The Staff Developer will educate Administrative Nursing Staff on reporting regulations. February 1, 2010. **b.** Administrative staff will be educated by Staff Developer on Incident and Concern form completion. February 1, 2010. **c.** Incident reports and concern forms will be brought to stand up and reviewed by D.O.N. to ensure that thorough investigations completed and timely reporting if appropriate. February 1, 2010. **4.** Audits on incident completion and Reporting to state agency will continue monthly. Results will be reviewed in quarterly QI meeting for a minimum of two quarters or until substantial compliance is achieved. February 1, 2010.	2/1/10 2/1/10 2/1/10 2/1/10

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F 225	Continued From page 7 2. Cross refer F166. On 5/13/09 a family member made the facility aware that on 5/13/09 at 5:50 AM a staff person transferred the resident (who was on sternal precautions post heart surgery) by grabbing R87 around the ribs and roughly putting her back to bed. Interviews with the Social Worker (E4) and DON (E2) revealed that there was no incident report or concern form about this incident. There was no evidence that the facility reported this allegation of mistreatment to the state agency. There was no evidence that the facility thoroughly investigated this allegation.	F 225	**F 241 Dignity** **1.** Facility was informed of incident after the event occurred. Resident did receive lunch. **2.** After being informed, Corporate Staff monitored dining rooms to ensure all residents were being fed at the same table at the same time. No corrective action was indicated at that time. December 2, 2010. **3.** **a.** Nursing staff will be educated by Staff Developer on Meal Delivery process. February 1, 2010. **b.** Food Service Director/designee will conduct weekly dining room rounds to ensure that all residents at the same table receive and are fed at the same time. February 1, 2010. **4.** Results of dining room audits will be reviewed in quarterly QI meeting for a minimum of two quarters or until substantial compliance is achieved. February 1, 2010.	2/1/10 2/1/10 2/1/10
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that one (R113) out of 43 sampled residents was treated with dignity during dining. Findings include: On 11/16/09 at 12 noon R113 was observed sitting at a table with 3 other residents who were eating or being fed their lunch. R113 had no tray and was not being fed. All aides on the unit were feeding other residents at the time, one nurse was passing medications and the other was			

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F 241	Continued From page 8 sitting at the nurses' station. At 12:17 PM staff started feeding the resident her lunch.	F 241		
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that one (R13) out of 43 residents received reasonable accommodations of their individual needs. Findings include: On 11/13/09, the Division of Long Term Care Residents Protection's investigator observed a call bell which was activated at approximately 9:49 AM by R13. The investigator observed two staff members; staff nurse (E18) and a certified nursing assistant (E16) when the call bell was activated in the unit. At approximately 10:15 AM, E16 answered the call bell and informed R13 that due to her work restrictions, she would not be able to provide the care needed and she would inform R13's assigned certified nursing assistant (CNA). E16 then turned off the call bell and left. At approximately 10:45 AM, almost thirty minutes later, R13's assigned CNA (E17) came into R13's room to provide toileting assistance.		**F 246 Accommodation of Needs** **1.** R13 was toileted by a member of nursing staff. **2.** Nursing Administration staff and charge nurses will monitor call bell response on an ongoing basis. **3.** **a.** Staff Developer will conduct staff education on the timeframes for and appropriate responses to, call bells. February 1, 2010. **b.** NHA/designee will audit all units weekly for timeliness and staff responsiveness to call bells. Corrective action will be taken as necessary. February 1, 2010. **4.** Call bell response will be reported in quarterly QI meeting for a minimum of two quarters or until substantial compliance is achieved. February 1, 2010.	2/1/10 2/1/10 2/1/10
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 9 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review it was determined that the facility failed to ensure one (R186) out of 43 sampled residents had a care plan developed for a newly assessed care need. The resident developed and was being treated for excess body fluid. Findings include: R186 was admitted on 6/8/08 post surgery for a fractured hip. Nurses' notes revealed the resident started developing edema to the lower extremities. On 6/24/09 physician's orders included Lasix 20 mg daily for 7 days and ted hose to bilateral extremities on at 7 am and off at bedtime. The doctor increased the Lasix dose on 6/29/09 for continued edema to the lower		**F 279 Comprehensive Care Plans.** **1.** R186 no longer resides at the facility. **2.** Records of residents with a diagnosis of CHF diagnosis currently being treated with lasix will be audited by DON/designee for appropriate care planning. Corrective measures will be taken as necessary. **3.** **a.** Nursing staff will be educated by Staff Developer of the need to care plan all diagnoses/problems currently being treated. February 1, 2010. **b.** Monthly random audits of medical records of residents (40% of census) with diagnosis of CHF who are ordered lasix will be conducted by D.O.N./designee. February 1, 2010. **4.** All audits will be reviewed in quarterly QI meeting for a minimum of two quarters or until substantial compliance is achieved. February 1, 2010.	2/1/10 2/1/10 2/1/10

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F 279	Continued From page 10 extremities. Skin assessment notes revealed on 6/29 and 7/6/09 that the resident had reddened lower extremities with small open areas that weeped fluid. On 7/6/09 physician's orders documented a chest X-ray was done and the Lasix was increased again. On 7/8/09 physician's orders documented a 1200 cc fluid restriction was initiated. On 7/10/09 the resident was admitted to the hospital with congestive heart failure and returned to the facility on 7/13/09. The resident was discharged from the facility on 10/5/09. The facility never initiated a care plan for the resident's development of fluid overload from congestive heart failure.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.		**F 280 Comprehensive Care Plans** **1.** a. R186's care plan was updated for offloading heels on 7/31/09. Pressure ulcers have healed. b. R128's care plan was updated on 12/4/09. c. R119 was discharged from facility 12/2/09. d. R234 was discharged from facility on 2/6/09. 2. D.O.N. /designee will audit medical records of residents (40% of census) for comprehensive care planning. Care planning to include offloading heels for hip fractures, additional fluids offered for hydration, interventions recommended from fall committee and specific behaviors describing resident's anxiety. Corrective action will be taken as necessary.	

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F 280	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure four (R186, R128, R119, and R234) out of 43 sampled residents had their care plans revised when changes in care were implemented. Findings include: 1. Cross refer F314. R186 was admitted post surgery from a repair of a fractured right hip and had a care plan for the potential risk of developing pressure ulcers. The care plan did not include an approach to relieve or off load pressure to the heels. The resident developed a pressure ulcer to the right heel on 6/29/09. The approach of off loading heels was added to the treatment record on 6/30/09 but failed to be added to the care plan. This intervention was not added to the care plan until 7/31/09. This was confirmed by interview with the unit manager (E6) on 11/24/09. 2. Cross refer F323. R128 had a fall on 9/28/09 in which the incident investigation indicated the resident tripped over his wheelchair foot rests. This was not indicated on the care plan and no new approaches for preventing falls related to the foot rests were added. On 11/11/09 a nurse's note and incident investigation revealed that the resident again fell as a result of tripping over his foot rests while standing and attempting to walk. An interview with	F 280	**3.** **a.** RNs/LPNs will be in-serviced by Staff Developer on updating care plan for offloading heels for hip fractures, additional fluids offered for hydration, interventions recommended from fall committee, and specific behaviors describing resident's anxiety .February 1, 2010. **b.** Random audits of care plans will be completed monthly by D.O.N./designee to confirm updates have been made as changes in status/treatment occur. February 1, 2010. **4.** Audits will be reviewed in quarterly QI meeting for a minimum two quarters or until substantial compliance is achieved. February 1, 2010.	2/1/10 2/1/10 2/1/10

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F 280	Continued From page 12 the unit manager (E5) revealed that after this fall the leg rests were to be disengaged from the wheelchair when the resident was just sitting and would only be used for transportation. The approach was not added to the care plan. 3. Cross refer F329 example #4. R119 was admitted to the facility on 10/22/09 with a change in mental status. On 10/29/09 a physician's order was written for Ativan (anxiety medication) 0.5 mg every six hours as need for anxiety. The behaviors describing the anxiety were not identified. Care plans for psychotropic medications and depression were initiated on 11/4/09, but failed to include any reference to anxiety, behaviors related to anxiety, the use of Ativan and it's side effects, and non pharmacological interventions. 4. Cross refer F327. R234 was ordered 120 cc (cubic centimeters) of fluid with medication passes on 1/30/09. Review of the care plan for potential for dehydration implemented on 1/9/09 failed to include this intervention. Findings were reviewed with administrative staff during the exit conference on 12/2/09.	F 280		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:		**F 281 Comprehensive Care Plans – Professional Standards** **1.** R186's care plan was updated for offloading heels on 7/31/09. Pressure Ulcers have healed.	

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F 281	Continued From page 13 Based on record review and interview it was determined that for one (R186) out of 43 residents the facility failed to ensure current standards of practice for pressure ulcer prevention were implemented. Findings include: Cross refer F314. R186 was admitted to the facility on 6/08/09 from the hospital post right hip fracture with surgical repair. The resident's plan of care did not include any approaches to relieve pressure to the heels. A pressure ulcer risk assessment dated 6/10/09 indicated a moderate risk for skin breakdown. On 6/29/09 a weekly wound assessment indicated the resident developed a pressure ulcer to the right heel. On 7/2/09 a weekly wound assessment indicated the resident developed a pressure ulcer to the left heel. Off loading of the heels was initiated on 6/30/09. The Wound, Ostomy and Continence Nurses Guidelines stated, "Relieve pressure to heels by using pillows or other devices. Pillows under calves decrease heel interface pressures (Tymec, Pieper, & Bollman, 1997)". The facility's policy Pressure Ulcer Prevention and Management instructed staff to consider interventions including off loading heels when in bed.	F 281	**2.** D.O.N./designee will audit all records of residents with new hip factures to confirm the treatment plan includes offloading of heels. Ongoing. **a.** Staff developer will in-service nursing staff regarding the need to include the offloading of heels in the treatment plan of any resident with a newly fractured hip. February 1, 2010. **b.** All residents with hip factures will come through high risk meeting following admission to ensure that the care plan reflects off loading of heels. February 1, 2010. **c.** DON/designee will complete weekly rounds to confirm that residents with a newly fractured hip have heels offloaded. February 1, 2010. **3.** Audits of newly admitted hip fracture records will continue weekly. Results will be reviewed in quarterly QI meeting for a minimum two quarters or until substantial compliance is achieved. February 1, 2010.	ONGOING 2/1/10 2/1/10 2/1/10 2/1/10
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

JAN 07 2010

Director's Office

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F 309	Continued From page 14 and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of other documentation as indicated and interview, the facility failed to ensure that one resident (R65) out of 45 sampled residents received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. On 10/30/09, R65 sustained skin tears to her shins accompanied by severe pain while being transferred from the stretcher to the bed by medics. While the medical transportation service was responsible for the injuries to R65's legs, the facility failed to provide thorough assessments and close monitoring of the wounds. The facility failed to perform complete vital signs (temperature, pulse, blood pressure, and respirations) and there were no nurses notes for R65 from 10/30/09 at 10:30 PM until 10/31/09 at 10 AM (about 12 hours). R65 was on the blood thinners Coumadin and Aspirin, which placed her at high risk for bleeding and bruising. Despite the adverse consequences of R65's active bleeding from her legs, the facility proceeded to administer Coumadin on 10/30/09. Additionally, the facility wrote a physician order for wound treatment on 10/30/09 without actually calling the physician. The wound care order did not coincide with the facility's policy for skin tear treatment and when steri-strips (pieces of sticky tape used to put edges of skin together) were applied to the wound, an order was not obtained. Findings include:	F	**F309 Quality of Care** **1.** R65 Resident remains a resident at Capitol Healthcare. The physician was notified on October 31, 2009. The right skin tear was treated with Silvadene BID and is completely healed. The left skin tear is vastly improved and is being treated Silvadene BID. **2.** All incident reports completed within the last 90 days will be reviewed by D.O.N./designee to ensure that residents were provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being with a comprehensive assessment and plan of care i.e. vital signs, physician notification, medication review and monitoring of the resident's medical status. Ongoing. **3.** **a.** Nursing staff will be educated by Staff Developer on incident follow-up including completion of incident reports, physician notification, medication regime review for side effects/complications, post-incident assessment, and care planning. February 1, 2010.	

Dana Smiles (12)

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F 309	Continued From page 15 The facility policy, entitled Notification of Resident Change in Condition, effective 11/1/08, stated, "...Related to medical care, the charge nurse will notify the... resident's physician... when there is: a. Accident with injury...". R65 was admitted to the facility on 12/20/07 with diagnoses including diabetes mellitus, anemia, and low back pain. Review of R65's 10/09 MAR (medication administration record) revealed that she received Children's Aspirin 81 mg every morning (8 AM) as an anticoagulant (prevents the clotting of blood) and Coumadin (anticoagulant) 6 mg daily at 4 PM. R65 also received two pain medications (Fioricet and Endocet) every morning at 8 AM. Review of R65's care plan revealed the problem, potential for injury related to the use of anticoagulation (bleeding/bruising), last revised on 9/10/09. Approaches included "Monitor for active bleeding...". A care plan for anemia, last revised on 8/27/09, listed the approach "Monitor for s/sxs (signs and symptoms) of bleeding, report problems to MD." Review of written medic statements, dated 10/30/09, revealed that at approximately 11:50 AM on 10/30/09, two medics returned R65 to the facility after some doctor appointments. While transferring R65 from the stretcher to the bed, the medics unfastened the top seatbelt, but failed to see the seatbelt across the residents legs which was covered by a blanket. As a result, only the top part of her body moved and R65 sustained a large skin tear on each shin. Medic reports stated that they applied direct pressure with 4x4's to control the bleeding, then wrapped Kling (rolled	F 309	**b.** Incident reports will come to stand up meeting and will be reviewed for completion, including physician notification and vital signs. February 1, 2010. **c.** Monthly the D.O.N./designee will conduct a random audit (20%) of incident reports against nursing notes and care plans to ensure compliance. February 1, 2010. **4.** Results of monthly audits will be reviewed in quarterly QI meetings for a minimum two quarters or until substantial compliance is achieved. February 1, 2010.	

Dana Smiles (to)

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F 309	Continued From page 16 guaze) around each leg. Review of all nurse's notes (NN) from post injury 10/30/09 through 10/31/09 AM revealed: 10/30/09 (2:30 PM)- "... returned from Drs appointment with a big skin tear on her left lower leg and another skin tear on Rt lower leg... pain medicated prior to the treatment (of legs)...". 10/30/09 (2230)- "... continue to monitor... continue to observe...". 10/31/09 (untimed)- listed as a late entry for 3/30/09- confirmed to be an error and should have been 10/30/09- "... L (left) lower leg laceration approximately 13 cm long and bloody, R (right) leg laceration 10 cm. Tx (treatment) was initiated steri-strip around 1330 (1:30 PM)... Percocet given at 1900 (7 PM) for c/o (complaints of) pain dressing change x2 soaked of blood on 3-11 (shift). T (temperature) 98.8...". 10/31/09 (10 AM)- "... assess BLE (bilateral lower extremities) & perform routine tx... BLE dressing c (with) fresh red blood towel beneath legs c fresh blood & old blood noted... LLE (left lower extremity-leg) c bruising to knee and toes... noted to have bruising to R elbow. Bruises dark purple in color. Dressings left intact. BLE elevated... (physician- E22) made aware N.O. (new order) for ice to BLE & to send resident to ER not 911... ASA (Aspirin) held... Cont. c bleeding @ this time... Cont c BLE pain...". Review of NN's revealed infrequent, minimal wound assessments. R65 was not assessed from 10:30 PM on 10/30/09 until 10 AM on 10/31/09 (approximately 12 hours), at which time she was sent to the ER for sutures to control the bleeding.	F 309		

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F 309	Continued From page 17 Review of ER records, dated 10/31/09, stated, "RLE sutured c #2 sutures... to control bleeding. Surgicell (gel pad that stops bleeding) adaptic, 4x4's, & Kling applied LLE wound... steri strips removed...". The facility administered Coumadin 6 mg at 4 PM on 10/30/09 to R65, despite the fact that she exhibited the adverse consequence of bleeding. E19 (wound nurse/charge unit manager) wrote an untimed telephone order on 10/30/09 for "Cleanse BLE skin tears c NSS (normal saline solution) apply Bacitracin BID (twice a day) until healed no tape on resident skin." Facility standing orders included skin tear protocol for "... a simple skin tear... no deeper than the epidermal layer (outermost layer of skin): *Cleanse the area with normal saline solution *Apply Vaseline and a non-adherent dressing once daily until healed... report any changes that would require additional intervention...". Additional interventions were required as steri-strips were applied by the facility on 10/30/09. Although R65 had care plans to report bleeding and changes in pain to the MD, and required interventions beyond the facility skin tear policy, the facility failed to notify the physician of R65's injuries sustained on 10/30/09 until nearly 24 hours later. Additionally, E19 failed to follow facility policy in the wound order she wrote and implemented on 10/30/09 and E19 falsely wrote that the wound order was obtained from E22 (MD) via telephone, when E22 was not consulted until 10/31/09. Additionally, the facility failed to obtain an order for the steri-strips.	F 309		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING	F 312		

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F 312	Continued From page 18 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, review of other documentation as indicated, and interview, it was determined that the facility failed to provide incontinence care for R15 from approximately 7 AM until 2 PM (7 hours) on 11/6/09. R15, who was dependent on staff for this care, was found saturated with urine, including her linens and mattress by E24 (certified nurses aide). Findings include: Review of a quarterly MDS (minimum data set) assessment, dated 10/5/09, revealed that R15 was a "4-4" or incontinent (not in control of) bowel and bladder function. She required extensive staff assistance with bed mobility (ability to reposition self in bed and turn side to side) and was non-ambulatory. A nurse's note, dated 11/6/09 and timed 2:30 PM, stated, "... Spoke to res who stated she was not provided care this morning after 7 am...". Review of the facility's incident report, dated 11/6/09, stated, "Res not provided care- brief & bed soaked c (with) urine, up back area". Review of the facility's investigation included a written statement by E24 (certified nurses aide-CNA), dated 11/6/09, which stated, "Went to feed lunch, res told me she was not changed in the morning... Res soaked, lying in brown urine in		**F312 Activities Of Daily Living** **1.** R15's assigned nursing assistant accompanied another resident on a transport and reassignment of resident did not occur. Facility attended to the R15's needs once the care issue was identified. Additionally the facility conducted a complete skin check to ensure that resident did not experience skin integrity issues. **2.** Since annual survey no incidences have been reported. Ongoing. **3.** **a.** Unit Managers/ Supervisors will be educated by Staff Developer on the need to review assignments when changes are made. When nursing assistants are deployed on transports, Unit Managers /Supervisor will ensure that all residents are accounted for in a reassignment. February 1, 2010. **b.** Monthly random assignment audits will be completed by D.O.N./designee monthly. February 1, 2010. **3.** Audits will be reviewed in quarterly QI meeting for a minimum two quarters or until substantial compliance is achieved. February 1, 2010.	ONGOING 2/1/10 2/1/10 2/1/10

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F 312	Continued From page 19 bed." E25 (CNA) wrote in a statement, dated 11/6/09, "Bed soaked in urine, strong odor... Res changed & nurse notified." E24 and E25 stated that their observations were made at 1:50 PM. During an interview with the facility on 11/6/09, E15 (CNA assigned to R15), stated that R15 "... is always bathed and dressed by 11-7 shift... was asked to go on a transport at 11:00... did not return... until 1420 (2:20 PM)... while she was gone, her group should have been split between the other C.N.A.'s...". E24 was interviewed by a Division of Long Term Care Residents Protection investigator on 11/13/09. E24 stated, "... Resident is a heavy wetter and has to be changed every two hours...". The facility failed to reassign R15 to another CNA when E15 was sent on transport.	F 312		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that one (R186) out of 43 residents developed two avoidable pressure sores while residing in the facility. The facility failed to implement off loading of the resident's heels to prevent breakdown resulting in pressure ulcers to		**F 314 Pressure Ulcers** **1.** R186's care plan was updated for offloading heels on 7/31/09. Pressure Ulcers have healed. **2.** **a.** D.O.N./designee will round on all residents with healing hip factures to ensure that heels are offloaded. Corrective action will be implemented as indicated. Ongoing. **b.** D.O.N./designee will audit all C.N.A. flow records of residents with healing hip fractures to ensure that offloading off heels are documented and signed off on. Ongoing.	ONGOING ONGOING

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F 314	Continued From page 20 both of the resident's heels. Findings include: R186 was admitted to the facility on 6/08/09 from the hospital post right hip fracture with surgical repair and diagnoses which included dementia, hypertension, anemia and hypothyroidism. The resident admission assessment done by nursing on 6/8/09 noted that both heels were red. A pressure ulcer risk assessment dated 6/10/09 indicated a moderate risk for skin breakdown. An admission care plan for potential of pressure ulcers was initiated on 6/8/09, but did not include pressure relieving measures for the heels. The full care plan established on 6/16/09 for potential for pressure ulcers related to decreased mobility and incontinence and did not specifically address pressure relief to heels. R186's admission MDS indicated the need for extensive assistance with two person physical assist for transfers and bed mobility. Review of the MAR, TAR and aide flow sheets for the month of June 2009 did not include an approach to off load or relieve pressure to the heels. In mid June 2009 R186 started developing edema (swelling) to the lower extremities. Skin rounds done on 6/22/09 documented bilateral lower extremities to be reddened with multiple open areas that were being covered with gauze wrap. On 6/24/09 the physician ordered Lasix 20 mg for 7 days (diuretic to reduce fluid from body). No new approaches were added to the care plan related to the lower extremity edema and/or pressure relief to the lower extremities. On 6/29/09 nurse's notes and a weekly wound	F 314	**c.** D.O.N./designee will audit care plans of all residents with healing hip fractures to ensure that edema if applicable and pressure relief devices are care planned. Ongoing. **3.** **a.** Staff developer will in-service nursing staff regarding the need to ensure the offloading of heels for any resident with a newly fractured hip. February 1, 2010. **b.** All residents with hip factures will come through high risk meeting following admission to ensure that the care plan reflects off loading of heels and edema if applicable. February 1, 2010. **c.** DON/designee will complete weekly rounds to confirm that residents with a newly fractured hip have heels offloaded. February 1, 2010. **4.** Results of rounds will be reviewed in quarterly QI meeting for a minimum two quarters or until substantial compliance is achieved. February 1, 2010.	ONGOING 2/1/10 2/1/10 2/1/10 2/1/10

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F 314	Continued From page 21 assessment report documented an unstageable 2.5 by 3 cm pressure ulcer to the right heel described as a fluid filled blister. On 7/17/09 it presented as a dark scab. On 6/30/09 an order was obtained to off load the resident's heels. On 7/2/09 a weekly wound assessment described the presence of an unstageable area to the left heel 3.5 by 4 cm, which was mushy. On 7/17/09 it presented as a dry thick dark scab. The right heel was healed on 8/14/09. On 9/30/09 the left heel was a 0.5 by 0.8 cm dried scab area. The resident was discharged home on 10/5/09. An interview with the unit manager (E6) on 11/24/09 confirmed that off loading of the heels was not initiated until after the right heel developed a pressure ulcer. An interview with the physician (E22) who is also the medical director on 11/24/09 revealed that off loading of the heels was not initiated until after the heels developed pressure ulcers. He further stated that the edema to the lower extremities may have contributed to the breakdown.	F 314		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		

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	085048	A. BUILDING _____ B. WING _____	C 12/02/2009

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F 323	Continued From page 22 by: Based on observation, record review and interview it was determined that for one (R128) out of 43 sampled residents the facility failed to ensure the resident's environment was free from accident hazards for a fall. Findings include: R128 was admitted on 6/25/09 and had diagnoses which included dementia, hallucinations and altered mental status. The resident's initial MDS dated 7/2/09 indicated the resident required extensive assistance with transfer, did not ambulate and used a wheelchair. R128's quarterly MDS dated 9/24/09 indicated extensive assistance with transfers and ambulation. On 9/28/09 a nurse's note documented that the resident got up from the wheelchair and fell to his knees. An interview with an aide (E9) who witnessed the fall documented that the resident stood up from his wheelchair, stepped forward and tripped over his foot rests. The resident's care plan was updated on 9/29/09 only to include the fact that the resident fell before staff could intervene. A nurse's note dated 11/11/09 documented the resident tripped over wheelchair legs and fell onto the floor from a standing position. R128 was found lying on the floor. The resident was assessed in the emergency room and found to have no injury. Again the care plan was only updated to indicate that the resident fell in the hallway. Review of the facility's incident report indicated the resident would be trialed on every 15 minute		**F 323 Accidents and Supervision** **1.** R128's care plan was updated on 12/4/09. **2.** D.O.N./Designee will audit any falls that occurred in the last 90 days to ensure that fall interventions have been implemented and documented. Corrective action will be taken as indicated. **3.** **a.** Fall Review Team will be educated by Staff Developer on the need to ensure all interventions recommended are documented and communicated to appropriate parties. February 1, 2010 **b.**Monthly random audits of the implementation of fall interventions will be conducted by D.O.N./designee. February 1, 2010. **4.** Audits will be reviewed in quarterly QI meeting for a minimum two quarters or until substantial compliance is achieved. February 1, 2010.	2/1/10 2/1/10 2/1/10

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F 323	Continued From page 23 checks and to continue with current safety measures. An interview with the unit manager (E5) on 12/1/09 revealed that after the 11/11/09 fall it was decided to remove or disengage the foot rests when the resident was sitting and to use them only for transportation. E5 further stated that this was not added to care plan or aide flow sheet, but was communicated verbally to staff. She was not aware that the foot rests had been a tripping hazard for the 9/28/09 fall. Observations made by survey staff between 11/16/09 and 11/30/09 revealed that the resident had foot rests in place on the wheelchair while sitting at the nurses station and at activities.	F 323		
F 327 SS=G	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to ensure that one (R234) out of 43 sampled residents was provided with sufficient fluid intake to maintain proper hydration and health. The facility failed to properly assess and identify the increased risk of dehydration for R234 when the resident experienced diarrhea, had changes in mental status, lost approximately 12 pounds (#) in one week and an additional seven pounds the following week while continuing to receive Lasix (diuretic) 80 mg. (milligrams) on a daily basis. The facility failed to respond in a timely manner to		**F327 Hydration** 1. R234 was discharged to home on 2/6/09. 2. **a.** D.O.N./designee will audit all weight books to ensure that physician, family and RD were notified of weight loss and residents were reweighed according to facility policy. Ongoing. **b.** D.O.N./designee will audit the records of residents receiving extra fluids to ensure evidence of fluid administration is properly documented on MAR. Ongoing,	ONGOING ONGOING

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F 327	Continued From page 24 address the above risk factors and failed to closely monitor R234 which resulted in abnormal laboratory values indicating dehydration and requiring intravenous (IV) fluids through the veins. In addition, when the facility identified the presence of the dehydration, the facility failed to ensure aggressive oral hydration of an additional 120 cc (cubic centimeter) of fluids with each medication pass (five times per day) was carried out consistently. Findings include: R234 was initially admitted to the facility on 1/6/09 with diagnoses including impacted left humerus [arm] fracture (fractured on 1/1/09), urinary tract infection, legally blind, congestive heart failure and chronic renal insufficiency. Review of the admission MDS assessment dated 1/10/09 documented that R234 was independent with daily decision making, was moderately impaired for vision, had partial loss of one side [left] of the body of arm and leg, required extensive assistance of one staff for eating, and was frequently incontinent of bowel and bladder. In addition, R234's height and weight was 64 inches and 225 pounds (#) respectively. Subsequent MDS assessments dated 1/16/09 and 2/2/09 noted R234 was independent with eating and required set-up only and that her weight was 230# and 211# respectively (noted resident triggered for 5% or more wt loss within last 30 days). The admission blood work at the facility dated 1/6/09 indicated that the resident's blood urea nitrogen (BUN) level was elevated at 31 (normal range 10-26 mg /dl) and that the creatinine (creat.) level was elevated at 1.7 (normal range 0.5-1.5 mg/dl). In addition, the sodium level was within normal at 139 (normal range 135-145 mmol/L). BUN, creatinine, and sodium levels are	F 327	3. **a.** Nursing staff will be educated by Staff Developer on the High Risk policy that identifies residents that are at risk for fluid deficit. See attached policy. **b.** Residents that are identified for fluid deficit will be placed on hydration monitoring which includes a physical assessment for signs and symptoms of dehydration. This is the facility's system to monitor resident's fluid consumption and physical assessment. See attached. February 1, 2010. **c.** Licensed nursing and nursing assistants will be educated by Staff Developer on weight policy. February 1, 2010. **d.** Licensed nurses will be educated by Staff Developer on reporting of abnormal lab results to physician. February 1, 2010. **e.** Monthly audits will be conducted by D.O.N./designee on labs, physician notification, nursing documentation of change in status, weight loss, hydration monitoring, and MARs to ensure compliance. February 1, 2010. 4. Audits will be reviewed in quarterly QI meeting for a minimum two quarters or until substantial compliance is achieved. February 1, 2010.	2/1/10 2/1/10 2/1/10 2/1/10 2/1/10

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F 327	Continued From page 25 indicators of fluid imbalance and renal function. Initial registered dietician (RD) assessment dated 1/8/09 documented R234's estimated fluid requirement of 1,989 cc per day and that the resident was at "no to low risk" for hydration issues. RD progress note dated 1/12/09 documented average meal intake of 95 % with 1,066 cc fluids from meals. In addition, weight was stable between 225# (1/6/09) and 229.8# (1/10/09). The care plan for potential for alteration in nutrition implemented on 1/8/09 included the following approaches: - encourage oral fluids. - monitor oral intake, labs, weights, skin, medications, and hydration. The goals included adequate hydration. There was no update on this care plan. The resident's care plan for potential for dehydration implemented on 1/9/09 included the following approaches: - encourage fluid consumption and to monitor adequate intake. - monitor labs as available. - monitor level of consciousness changes. The goal included that R234 will have no signs or symptoms of dehydration. Although the resident was noted to have increasing BUN and creatine along with weight loss, the only revision in the care plan was noted on 2/3/09. The 2/3/09 revision noted that on 1/30/09, the physician was notified of BUN 90 (incorrect information since BUN was 97); creat. 2.4 and that IV fluids were initiated. Lab result on 2/2/09 was BUN 80; creat. 2.0. Will continue to observe/monitor. Fluids have been encouraged and given to R234	F 327		

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F 327	Continued From page 26 frequently secondary to impaired vision, also noted with some occasional confusion recently. Attending physician (E22) progress note dated 1/21/09 noted R234 complaints of frequent loose stool and an order to test the stool for clostridium difficile was ordered (1/26/09 negative result obtained). Although this note documented complaints of frequent loose stool, review of the nurses notes from admission 1/6/09 through 1/31/09 failed to document any loose stool. Review of weekly weights noted the following: 1/17/09 230.1# 1/24/09 218.0# (approximately 12# loss) Review of facility's policy titled "Weights-Taking and Recording Monthly and Weekly" noted re-weights will be done on any resident who experienced a 10 # weight fluctuation and is >or = to 200# and that re-weight will be done within 24 hours with the presence of a nurse and once the fluctuation has been confirmed, the Dietician/designee will be notified and that the resident will be reported at the next weekly High Risk Committee by the RD/or designee and the Unit Manager/Designee will notify the resident's physician and family member. Record review lacked evidence of a re-weight, a referral to the RD, the High Risk Committee, notification of the attending physician, or a family notification. Above findings were reviewed with the administrator (E1) and Director of Nursing (E2) on 12/2/09 at approximately 1:45 PM. In addition, interview with the attending physician (E22) on 12/2/09 at approximately 2:30 PM revealed that he does not recall whether he was notified of the approximate 12 # weight loss, however, as the	F 327		

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F 327	Continued From page 27 facility's medical director, with this weight loss, the expectation was that the physician be notified as well as the family and the resident's condition be discussed in the High Risk Committee. Subsequent review of laboratory results dated 1/24/09 indicated both BUN and creat. were abnormal at 65 and 2.0 respectively. A handwritten initial by the attending physician (E22) was noted on the document and with a date of "2/11/09." An interview with E22 on 12/2/09 at approximately 2:30 PM revealed that he does not recall whether he was notified of the results on 1/24/09 and that the initial and date reflected the date when he physically saw the report in the facility. Review of the "24 hours report" for 1/24/09 with the DON (E2) on 12/1/09 at approximately 11 AM confirmed that there was no communication of the abnormal laboratory result for R234 in the 24 hour report or in the nurse's notes. Review of nurse's note dated 1/25/09 timed 7 AM-7 PM noted changes in mental status with resident being confused and disoriented. The attending physician was notified and an order was received for urine culture and sensitivity (results negative on 1/30/09 for infection). Although R234's fluid consumption was documented on the CNA Food Intake from 1/24/09 through 1/29/09 it was noted that R234's fluid intake was less than half of her estimated need, there was no nursing or dietician response. Review of 1/30/09 BUN and creat. noted increased results at 97 and 2.4 respectively. E22 was contacted and the following physician order	F 327		

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F 327	Continued From page 28 and interventions were initiated: - to give 120 cc of extra fluids per medication pass (five med pass scheduled per day) - decrease Lasix to 40 mg. daily - one liter of normal saline at 125 cc per hour IV Nurse's note dated 2/1/09 timed 7 AM - 7 PM noted "chronic diarrhea" and medicated with Kaopectate. Also, that the episodes of diarrhea were not as frequent but needs to be monitored for future episodes. Even though this note indicated chronic diarrhea, review of the January Medication Administration Record (MAR) lacked any evidence of that the Kaopectate was administered. Interview with the DON and Unit Manager on 2/8/09 at approximately 9:30 AM confirmed the lack of documentation. Subsequent to the above complaint of diarrhea, on 2/3/09, the resident was ordered Imodium 2 mg. capsule every four hours as needed which R234 received three doses each day on 2/4/09 and 2/5/09. Review of the January 2009 MAR revealed that R234 was provided the additional 120 cc of extra fluids per med pass (five med pass per day). Next weekly weight on 1/31/09 was 211.4#, approximately seven (7) additional pound loss in one week. Despite an order for extra 120 cc of fluids per med pass, review of February 2009 (MAR) from 2/1/09 through 2/5/09 lacked evidence that these fluids were given to R234. The MAR revealed a hand-written intervention of "120 cc extra fluids per med pass, however, there was no signature by the staff nurses which indicated that these	F 327		

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F 327	Continued From page 29 additional fluids were given to R234. Review of R234's fluid consumption, as documented on the CNA Food Intake document from 2/1/09 through 2/5/09 noted R234's fluid intake to be only 540cc, 720cc, 420cc, 480cc, and 720cc. An interview with the DON (E2) and the Unit Manager (E6) on 12/2/09 at approximately 10 AM revealed that the extra fluids would have been documented on the MAR and in addition, E2 and E6 confirmed that no tracking of total fluids on a daily basis was being completed for R234. Thus, the facility failed to have a system to monitor R234's fluid consumption. On 2/2/09, BUN was 80 and creat. 2.0 and nurse's note dated 2/2/09 timed 2:30 PM documented results faxed to attending physician's office per on call physician's request. On 2/3/09, order received from E22 for an additional one liter of normal saline via IV which was administered on 2/3/09. Physician progress note by E22 dated 2/4/09 noted R234 "Feeling a little better today but still tired, some dyspnea, still having loose BM (bowel movement)". Under assessment "(A)/plan (P): Azotemia (the accumulation of abnormally large amounts of nitrogen containing compounds such as urea, creatine, various body waste compounds in the blood)/CKD recheck labs today, continue aggressive p.o. (oral) hydration." Review of 2/5/09 laboratory result noted BUN and creat. of 89 and 2.2 respectively and E22 was contacted. Order received for one additional liter of normal saline at 125 cc per hour. Nurse's note	F 327		

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F 327	Continued From page 30 dated 2/5/09 and timed 4PM noted unable to start IV at the facility and that E22 was notified. An order was received to send R234 to the hospital for insertion of a IV line in which R234 received one additional liter of normal saline fluid. Review of nurse's note dated 2/5/09 timed 3PM-11 PM shift noted resident returned from the emergency room and was noted to have dry mucous membranes during the nursing assessment. The facility failed to have a system in place to monitor R234's fluids which resulted in the resident requiring the administration of IV fluids.	F 327		
F 329 SS=E	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.		**F 329 Unnecessary Drugs** **1.** **a.** R126 continues on abilify and had an AIMs completed on 12/18/09. **b.** R141 continues on seroquel. AIMs were last completed on 11/3/09. **c.** R15's currently is ordered a weekly blood pressure and pulse. **d.** R119 was discharged from the facility. **e.** R128 is no longer ordered xanax. **2.** **a.** DON/designee to review the records of all residents with orders for antipsychotic medications to ensure an AIMs has been completed as per protocol. Corrective action to be implemented as needed. February 1, 2010. **b.** DON/designee to complete an audit of 40% of open records to ensure that vital signs are completed as per order. Corrective action to be implemented as needed. February 1, 2010.	2/1/10 2/1/10

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F 329	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of facility policy, it was determined that the facility failed to evaluate and monitor five residents (R15, R119, R126, R128 and R141) out of 43 sampled residents. The facility failed to consistently perform AIMS (Abnormal Involuntary Movement Scale) evaluations for R126 and R141 and vital signs, including pulses, weekly as ordered by the physician for R15 who was on two blood pressure medications with the potential adverse effect of bradycardia (abnormally low pulse). The facility also failed to initiate behavior monitoring for R119 to evaluate the behavior and effectiveness of Ativan (for anxiety) and to evaluate and monitor for adverse consequences from Xanax (for anxiety), a new medication for R128, which resulted in a fall. Findings include: Review of the facility policy titled "AIM's Testing" noted that all residents receiving an antipsychotic drug will receive routine monitoring by the use of the Abnormal Involuntary Movement Scale (AIMS) to monitor for symptoms of Tardive Dyskinesia. 1. Review of R126's 11/09 monthly physician's order sheet noted that R126 received Abilify (antipsychotic medication) 10 mg. (milligram) by mouth at bedtime and had received it since April 2009. Record review lacked evidence of any AIMS for R126. Interview with the Director of Nursing (E2) on 11/30/09 at approximately 11 AM confirmed	F 329	**c.** DON/designee to review the care plans of all residents ordered antipsychotic medications to ensure that the reason for use, and how that behavior is demonstrated is addressed as well actual use. February 1, 2010. **d.** DON/designee to audit for presence of Behavior Monitor sheets that accurately describes the behaviors demonstrated by the resident that is ordered Antianxiety medications. Ongoing. **e.** DON/designee to review MARs of any resident ordered a PRN Antianxiety medication to ensure nursing has documented the effectiveness of the medication. Ongoing. Corrective action to be implemented. **3.** **a.** Staff Developer to educate RNs and LPNs on the AIM's completion protocol, medications that warrant blood pressure monitoring, care plan completion for residents ordered Antianxiety medications to describe behaviors demonstrated, Behavior Monitor sheet completion to describe behaviors demonstrated, and documentation of the administration of PRN medications. February 1, 2010. **b.** Monthly audits of AIMs, Care Plans, Behavior Monitor Sheets, PRN Antianxiety medication, and Vital	2/1/10 ONGOING 2/1/10

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F 329	Continued From page 32 the above findings. 2. Review of R141's clinical record revealed that the resident received Risperidone (antipsychotic medication) 0.25 mg. by mouth twice a day since July 2009 and was switched to Seroquel (antipsychotic medication) 50 mg. every morning and 100 mg. every evening by mouth on 10/15/09. On 11/19/09, the Seroquel was increased to 150 mg. by mouth two times a day. Record review revealed AIMS dated 2/23/09 and 11/3/09. An interview with E2 on 11/24/09 at approximately 11:15 AM confirmed that an AIMS was not completed six months after the 2/23/09 assessment. An interview with E2 on 11/30/09 at approximately 11 AM confirmed the above findings. 3. Review of R15's 11/09 MAR (medication administration record) revealed that she received Lisinopril 20 mg one tablet daily at 10 AM and Metoprolol 50 mg one tablet twice a day at 10 AM and 10 PM for hypertension. Both of these medications can cause the adverse effect bradycardia. Vital signs (temperature, pulse, BP and respirations) were ordered to be done weekly on 10/22/08. Review of the 9/09 through 11/09 MARs revealed documentation of BP's only. Review of R15's Vital Sign Flow Sheet revealed that full vital signs were completed monthly, therefore R15's pulse was only being checked once per month although she was on medications with the potential to cause an abnormally low pulse. Findings were confirmed with E5 (unit manager) on 11/20/09.	F 329	Signs will be conducted by DON/designee. February 1, 2010. **4.** Audits will be reviewed in quarterly QI meeting for a minimum two quarters or until substantial compliance is achieved. February 1, 2010.	2/1/10 2/1/10

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	085048	A. BUILDING _____ B. WING _____	C 12/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE SERVICES	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 33 4. R119 was admitted to the facility on 10/22/09 with diagnoses which included altered mental status and depression. According to nurses' notes the resident was to receive therapy services and ambulation with a rolling walker with the minimal assistance of one person. On 10/29/09 a physician's order was written for Ativan (anxiety medication) 0.5 mg every six hours as needed for anxiety. The behaviors describing the anxiety were not identified. Review of nurses' notes between 10/22 and 10/29/09 lacked evidence of anxiety. However, nurses' notes described many attempts of the resident to get up unassisted and ambulate. Care plans for psychotropic medications and depression were initiated on 11/4/09, but failed to include any reference to anxiety, behaviors related to anxiety, the use of Ativan and it's side effects, and non pharmacological interventions. Review of the MAR documented that Ativan was administered nine times between 11/9 and 11/20/09 for anxiety and/or agitation. For five of the nine doses no results of the medication administration were documented. The other four doses were documented as effective. Review of the record also lacked evidence that behavior monitoring was initiated to evaluate the behavior and effectiveness of the treatment. Interviews on 11/20/09 with the unit manager (E6) and 11/23/09 with the ADON (E3) confirmed that behavior monitoring was not initiated. 5. R128 was admitted on 6/25/09 and had	F 329		

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F 329	Continued From page 34 diagnoses which included dementia, hallucinations and altered mental status. The resident's initial MDS dated 7/2/09 indicated the resident required extensive assistance with transfer, did not ambulate and used a wheelchair. R128's quarterly MDS dated 9/24/09 indicated extensive assistance with transfers and ambulation. Nurses notes on 6/27/09 documented on both day and evening shift that the resident was trying to get up and walk and was unstable on his feet. On 6/28/09 at 4 PM a physician's order was obtained for Xanax (anxiety medication with side effects that include impaired physical and mental capability) 0.5 mg twice a day for agitation. A corresponding nurse's note documented the order for Xanax was obtained for agitation and restlessness. The MAR indicated the Xanax was administered to the resident at 4 PM. At 5:10 PM R128 was found on the floor of the dining room by a visitor to the facility. The resident had been left unattended after the administration of a new medication that may cause sedation. The resident was treated and released in the emergency room with no significant injury found. A care plan for potential for falls was initiated on 6/29/09 that included the approaches of a tag alarm and to be in a supervised area when awake. The facility failed to evaluate and monitor R128 for adverse consequences from Xanax which resulted in a fall.	F 329		
F 367 SS=D	483.35(e) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the		**F367 Therapeutic Diets** 1. R58 continues on nectar thickened liquids. 2. FSD/designee will audit resident trays against menu ticket for those residents ordered thickened liquids to ensure appropriate consistencies is provided. Corrective measures will be taken as indicated. Ongoing.	ONGOING

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F 367	Continued From page 35 attending physician. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to provide the therapeutic diet prescribed by the physician for R58. R58 was observed drinking regular, unthickened liquids on 11/16/09 when she had nectar thickened liquids ordered. Findings include: On 11/16/09, R58 was observed feeding herself at lunchtime. She had 8 ounces of unthickened water and 4 ounces of unthickened cranberry juice. R58's menu ticket stated she was to have nectar thickened liquids and this was confirmed in her clinical record. Several staff members sat with R58 at various times while she ate. R58 began to drink her juice while E26 (activity aide) sat with her. E26 was advised that R58 had unthickened liquids which E26 confirmed. E26 subsequently threw R58's water away and R58 drank her juice before the cup could be removed.	F 367	3. **a.** Staff Developer will educate nursing assistants and dietary staff on reading meal tickets and to ensure proper liquid consistency is provided to residents. February 1, 2010. **b.** Audits of meal trays will be conducted by FSD/Designee on a monthly basis. February 1, 2010. 4. Audits will be reviewed in quarterly QI meeting for a minimum two quarters or until substantial compliance is achieved. February 1, 2010.	2/1/10 2/1/10 2/1/10
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		

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F 371	Continued From page 36 by: Based on observation and interview it was determined that the facility failed to serve food under sanitary conditions. Findings include: 1. On 11/16/09 between 11:40 AM and 12 Noon lunch observations were made on the Holly unit. Staff E11 and E12 were observed taking bread out of wax paper packets and handling it with their bare hands. There was no handwashing observed after handling the food tray from the cart, before handling the bread, or before assisting the next resident with their tray and bread. 2. On 11/20/09 at 11:50 AM all staff on the Holly unit were passing and setting up meal trays. All were wearing gloves while they removed the tray from the cart and set up the residents food. This included removing a roll from a wax paper packet. Staff would then remove their gloves and don new gloves before getting the next tray. There was no handwashing observed after handling the food tray from the cart, before handling the roll, or before assisting the next resident with their tray and roll. An interview on 11/20/09 with corporate staff (E13) who is also a dietitian confirmed that staff should wash hands and wear gloves or use a utensil to handle residents food.		**F 371 Sanitary Condition** 1. Facility was informed after the incident. 2. FSD/designee will audit all dining rooms to ensure appropriate sanitary measures are being implemented by staff when serving food to residents. Ongoing. 3. **a.** Staff Developer will educate all nursing assistants on sanitary methods when serving food to residents. **b.** Monthly Audits of meal delivery will be conducted by FSD/Designee. 4. Audits will be reviewed in quarterly QI meeting for a minimum two quarters or until substantial compliance is achieved. February 1, 2010.	01/20/10 2/1/10
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428		

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F 428	Continued From page 37 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to act upon the irregularity identified by the licensed pharmacist during a monthly drug regimen review for one out of 43 sampled residents. Findings include: Cross refer F329, example #1. Record review revealed that R126 was ordered and received Abilify (an antipsychotic medication) 10 mg. (milligram) by mouth at bedtime since April 2009, approximately seven months. Review of the Medication Regimen Review sheet indicated that the licensed pharmacist reported on 10/30/09 the lack of AIMS assessments for R126. Record review lacked evidence of any AIMS for R126. Interview with the Director of Nursing (E2) on 12/2/09 at approximately 11 AM confirmed the above findings.		**F428 Drug Regimen Review** **1.** R126 had an AIMs completed on 12/18/09. **2.** DON/designee to review the records of all residents with orders for antipsychotic medications to ensure an AIMs has been completed as per protocol. Corrective action to be implemented as needed. February 1, 2010. **3.** **a.** Staff Developer will conduct education with RNs and LPNs on the AIM completion protocol. February 1, 2010. **b.** Monthly audits of AIMs completion for those residents ordered antipsychotic medications will be conducted by DON/designee. February 1, 2010. **4.** Audits will be reviewed in quarterly QI meeting for a minimum two quarters or until substantial compliance is achieved. February 1, 2010.	2/1/10 2/1/10 2/1/10 2/1/10

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Capitol Healthcare Services

DATE SURVEY COMPLETED: December 02, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.	Enclosed is the Plan of Correction for Capitol Healthcare Services. Preparation and/or execution of this Plan of Correction do not constitute admission or agreement of the provider to the truth of the alleged conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law
3201	Regulations for Skilled and Intermediate Care Nursing Facilities An unannounced QIS annual survey and complaint visit was conducted at the facility from November 16, 2009 through December 2, 2009. The deficiencies contained in this survey are based on observations, interviews and review of residents' clinical records and review of other facility documentation as indicated. The survey sample included thirty (30) admission and forty (40) census residents in Stage I. The Stage II sample included forty-three (43) residents.	
3201.6.1	**Services to Residents**	
3201.6.1.1	**General Services** **The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.** **This requirement is not met as evidenced by:**	

Dana Smiles, DHR 12-30-09

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	Cross refer to the CMS 2567-L, survey date completed 12/2/09, F157, F166, F246, F281, F309, F312, F314, F323, F327, F329, F428.	Please cross reference POC F157, F166, F246, F281, F309, F312, F314, F323, F327, F329, and F428
3201.6.5	**Nursing Administration**	
3201.6.5.6	**A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L, survey date completed 12/2/09, F279.	Please cross reference POC F279
3201.6.5.7	**The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be**	

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	conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L, survey date completed 12/2/09, F280.	Please cross reference POC F280
3201.6.8	**Food Service**	
3201.6.8.1	**Meals**	
3201.6.8.1.5	**Therapeutic diets, mechanical alterations and changes in either must be prescribed by an attending physician within 72 hours of implementation. All meals and snacks shall be served in accordance with the therapeutic diet, if prescribed.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L, survey date completed 12/2/09, F367.	Please cross reference POC F367
3201.7.5	**Kitchen and Food Storage Areas**	
3201.7.5.1	**Facilities shall comply with the Delaware Food Code.**	

DELAWARE HEALTH AND SOCIAL SERVICES
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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	3-301.11 Preventing Contamination from Hands.* **(A) FOOD EMPLOYEES shall wash their hands as specified under § 2-301.12.** **(B) *Except when washing fruits and vegetables as specified under § 3-302.15 or when otherwise APPROVED*, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, SINGLE-USE gloves, or dispensing EQUIPMENT.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 12/2/09, F371.	Please cross reference POC F371
3201.10.5	**Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician**	

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	and licensing or law enforcement authorities, when appropriate. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L, survey date completed 12/2/09, F225, example #2.	Please cross reference POC F225
3201.10.6	**All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection. Telephone number: 1-877-453-0012; fax number: 1-877-264-8516.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L, survey date completed 12/2/09, F225, example #1.	Please cross reference POC F225
16 Del. C., Chapter 11, Subchapter II, §1121	**Rights of Patients** **Patient's Rights (1)** **Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in**	

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	compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality. **This requirement is not met as evidenced by:** Cross refer to the 2567-L, survey date completed 12/2/09, F241. **Patient's Rights (11)** **Every patient and resident may associate and communicate privately and without restriction with persons and groups of the patient's or resident's own choice (on the patient's or resident's own or their initiative) at any reasonable hour; may send and shall receive mail promptly and unopened; shall have access at any reasonable hour to a telephone where the patient may speak privately; and shall have access to writing instruments, stationery and postage.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L, survey date completed 12/2/09, F174.	Please cross reference POC F241 Please cross reference POC F174

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16 Del. C., Chapter 11, Subchapter III, §1132	**Reporting requirements** **(a) Any employee of a facility or anyone who provides services to a patient or resident of a facility on a regular or intermittent basis who has reasonable cause to believe that a patient or resident in a facility has been abused, mistreated, neglected or financially exploited shall immediately report such abuse, mistreatment, neglect or financial exploitation to the Department by oral communication. A written report shall be filed by the employee or service provider within 48 hours after the employee or service provider first gains knowledge of the abuse, mistreatment, neglect or financial exploitation.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L, survey date completed 12/2/09, F225, example #2.	Please cross reference POC F225
16 Del. C., Chapter 11, Subchapter VII, § 1162	**Nursing staffing** **(a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to**	

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	dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles. **This requirement is not met as evidenced by:** Based on observations made of staff working in the facility on 11/30/09, it was determined that the failed to ensure that every employee wore a nametag, prominently displaying his or her full name and title. Findings include: 1. E14 was observed to be on the Scott unit working with no nametag displayed. 2. E15 was observed to be on the Holly unit working with no nametag displayed. 3. E21 was observed throughout the facility working with individual residents with no	**1.** Once informed by surveyor, employees E14, E15, and E21 were told to display their name tags. **2.** Once informed by surveyor, NHA did rounds to ensure employees had name tags displayed. (11/30/09) **3.** NHA will do random audits to ensure employees are displaying name tags. ONGOING **4.** Audits will be reviewed in quarterly QI meeting for a minimum two quarters or until substantial compliance is achieved. (2/1/10)

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	nametag displayed.	